BHSF Form 1-L SSI
Rev. 1/11

Louisiana Medicaid Program

SSI Recipient Application

Long-Term Facility Care, Home and Community Based Services (HCBS), or Program of All Inclusive Care for the Elderly (PACE)

What language do you speak best? ❑ *English* ❑ *Spanish* ❑ *Vietnamese* ❑ *Other (specify)* _____
What language do you write best? ❑ *English* ❑ *Spanish* ❑ *Vietnamese* ❑ *Other (specify)* _____

1. Name of Applicant (person who needs long-term facility care, Home and Community Based waiver or PACE).

   Name (First, Middle Initial, Maiden, Last) _____

   Social Security #_____ Date of Birth_____

   Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Widowed

   Is the person in need of long term care a Veteran? ❑ Yes ❑ No If **yes**, VA Claim# _____

   Railroad Retirement#_____

   Residence address_____City_____State____Zip code_____

   Mailing address_____City_____State____Zip code_____

2. Who is the person responsible for handling the applicant's affairs?

   Name _____ Daytime phone # (____) _____

   Cell phone # (____) _____E-mail address _____

   Mailing address_____City_____State____Zip code_____

   Relationship to the applicant _____Does this person have power of attorney? ❑ Yes ❑ No

   If **no**, does someone else have power of attorney? ❑ Yes ❑ No If **yes**, who? _____

3. A. What is the applicant's current facility status? ❑ Lives in a nursing facility ❑ Plans to enter a facility

   Facility name _____ Date Entered the Facility _____

   B. Is the applicant applying for Home and Community Based Services (waiver)? ❑ Yes ❑ No

   Has the applicant been offered an opportunity (slot) for HCBS (waiver)? ❑ Yes ❑ No

   What type of HCBS (waiver) is the applicant applying for?

   ❑ Adult Day Health Care ❑ Children's Choice ❑ Elderly/ Disabled Adult ❑ New Opportunities

   Name of case management agency_____

   C. Is the applicant applying for the Program of All-Inclusive Care for the Elderly (PACE)? ❑ Yes ❑ No

4. Did the applicant move to Louisiana from another state? ❑ Yes ❑ No If **yes**, when? _____

   Does he or she intend to remain in Louisiana? ❑ Yes ❑ No

5. Does the applicant have a legal spouse who lives at home and/or any children under age 18?
❑ Yes ❑ No If **yes**, give us the following information about these people.

Name (First, Middle Initial, Last)	Social Security #	Does this person wish to apply for Medicaid	Date of Birth			Relationship to Applicant
			month	day	year	
		❑ Yes ❑ No				
		❑ Yes ❑ No				

6. Does the applicant or applicant's spouse have any income **other** than SSI (Supplemental Security Income)?
❑ Yes ❑ No What is the source and amount of the income? _____
If applying for long-term facility care, does the applicant wish to contribute part of this income to the legal spouse and/or any children under age 18? ❑ Yes ❑ No

7. Does the applicant or applicant's spouse work? ❑ Yes ❑ No If **yes,** give the name of employer and gross wages (income before any deductions).
_____
How often paid? _____

8. Did or will the applicant or the applicant's spouse receive any lump sum of money like an insurance or lawsuit settlement, inheritance, or retroactive Social Security payment? ❑ Yes ❑ No

If **yes**, who? _____Amount $_____ When? _____
From whom? _____For what reason? _____

9. Does the applicant and/or the applicant's spouse have any bank accounts or cash? ❑ Yes ❑ No
Name(s) on the account _____
Name and address of the bank or financial institution _____
Account Number _____Balance $_____

10. Has the applicant or applicant's spouse ever created a trust, placed any items in trust, or been named as the beneficiary of a trust? ❑ Yes ❑ No A copy of the trust will need to be provided.

11. Does the applicant, or applicant's spouse own or are they buying the **home** in which they live or any other properties?
❑ Yes ❑ No **If yes**, give address or location and description of the property. _____
_____
_____

12. Does the applicant or applicant's spouse have a share in an undivided estate or heir property? ❑ Yes ❑ No

If **yes,** give the following information.

Description of the property_____

_____

Value of the property $_____Amount owed on the property $_____

Number of other heirs _____

13. Has the applicant, the applicant's spouse, or anyone acting on their behalf sold, given away, or deeded any assets or property? ❑ Yes ❑ No If **yes**, give the following information.

What was given away, sold, or deeded? _____

To whom?_____ Date _____

14. Does the applicant have other health insurance, including Medicare supplements, that cover doctor and hospital visits? ❑ Yes ❑ No If **yes**, give the following information.

Name and address of company _____

Group/Policy # _____ Monthly Cost $_____

15. Does the applicant have life insurance with **combined** face value above $10,000? ❑ Yes ❑ No

If **yes**, amount? $_____ Name and address of companies_____

_____

_____Policy #(s)_____

20. Does the applicant have Long Term Care Partnership Insurance Policy? ❑ Yes ❑ No

Rights and Responsibilities

WHAT MEDICAID HAS THE RIGHT TO EXPECT OF YOU (the person applying for Medicaid)

CITIZENSHIP AND IMMIGRATION STATUS: You state that the information about citizenship and immigration status given at the beginning of this application form is true and correct.

REPORTING THE TRUTH: You state that the information you give on this application form is true and correct. You understand if you purposely give information that is not true or if you purposely do not tell information that you are supposed to, you may get health benefits that you should not get. If that happens, you can by law be punished for fraud. Also, you may have to pay money back to Medicaid for the bills it paid by mistake.

VERIFICATION OF INFORMATION: You understand that the information you give will be checked. You agree to help with this and let Medicaid get information it needs from government agencies, employers, medical providers, and others.

SOCIAL SECURITY NUMBERS: You understand Social Security numbers will only be used to get information from other government agencies to make a decision about your eligibility for Medicaid.

PAYMENT OF MEDICAL CARE BY A THIRD PARTY: You understand by accepting Medicaid, the Department has the right to get money received by you from other sources like insurance payments or lawsuit settlements for services that Medicaid

has paid for you.

REPORTING CHANGES: You agree to tell Medicaid within 10 days of these changes: 1) if you move out of state; 2) changes in mailing or home address; 3) if anyone moves in or out of your home; 4) changes in health insurance and premiums; 5) changes in income; and 6) changes in things you own.

CHILD SUPPORT ENFORCEMENT: You understand that Medicaid will only send information to Child Support Enforcement for medical support if you ask them to.

ANNUITIES: You agree that by accepting Medicaid, the State of Louisiana will be named as the remainder beneficiary of all annuities purchased on or after Feb. 8, 2006 for the total amount of medical assistance paid on your behalf, unless you have a spouse, minor child, or a child with a disability. In these cases, the State must be named as beneficiary after these individuals. You agree to tell Medicaid about any annuity you and your spouse own or co-own regardless if the annuity is irrevocable (cannot be changed) or Medicaid counts it. You understand that you must tell Medicaid about changes made to any annuity which may affect when payments begin, the amount paid, frequency of payments, and additions to the principal.

WHAT YOU (the person applying for Medicaid) HAVE THE RIGHT TO EXPECT FROM MEDICAID

RIGHT TO A FAIR HEARING: You understand that you can ask for a Fair Hearing if you think any decision made on the case is unfair, incorrect, or made too late.

NO DISCRIMINATION: You understand Medicaid cannot treat you differently because of race, color, sex, age, disability, religion, nationality, or political belief. If you think it has, you can call the U.S. DHHS Regional Office for Civil Rights in Dallas, TX at 1-800-368-1019 or write to Louisiana's Department of Health & Hospitals, Human Resources at P. O. Box 4818 Baton Rouge, LA 70821-4818.

OTHER SERVICES: You understand Medicaid will send you information about WIC, KIDMED, and other Medicaid services.

ESTATE RECOVERY: You understand that Estate Recovery rules require the Department to recover the cost of certain Medicaid payments from your estate. These costs include the total amount of payments for facility services, waiver services, hospital care, and prescription drugs received at age 55 or older by LTC and/or HCBS recipients. The Department will not make a claim against the estate while you or your legal spouse is still living or if you have a dependent child who is under age 21, blind, or disabled. Collection may not be made if it is not cost effective for the Department to do so, or if your heirs apply for a hardship waiver after your death and the hardship waiver is granted by the Department. A hardship may exist if the estate property is the only source of income for the heirs, if that income is limited, or other extenuating circumstances.

SIGN BELOW

Applicant or Representative Signs Here:_____ **Date**_____

Applicant's Spouse Signs Here:_____ **Date** _____

If anyone signs with an "X", two witnesses must sign.

_____ **Date**_____ _____ **Date**_____

If Medicaid filled out this application, they will sign here. _____ **Date**_____